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ABSTRACT

The increasing age of the American population and the current emphasis on cost containment in health care make the 1980s an ideal time for building bridges to span the health care needs of elderly persons in acute care and long-term care. While hospitals often discharge patients to nursing homes as an intermediate step between hospitalization and community-based care, other patients also move between the nursing home, hospital, and nursing home. Patient needs are often similar in all of these settings, so nurses need to integrate care between acute and long-term care facilities and employ a means of communication that will augment patient progress. Each level of care currently assesses older patients upon transfer, with each institution emphasizing problem identification according to its own focus of care. When each institution functions as a separate unit of care, the continuity in dealing with the priority problems identified from the previous level of care may get lost. Nursing diagnosis may be the way to bridge care gaps and communicate nursing care along the health care continuum. This document lists advantages in using nursing diagnosis among all levels of care, offers suggestions for initiation of this system as a care bridge between acute and long-term care, and identifies problems in instituting nursing diagnosis as a bridge between levels of care. A sample nursing diagnosis and plans for all levels of care are included.
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BUILDING CARE BRIDGES BETWEEN ACUTE
AND
LONG-TERM CARE WITH NURSING DIAGNOSIS

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The '80' are prime time for building bridges to span the health care needs of elderly people in acute care and long-term care. This topic is timely because of the increasing age of our population and because of the current emphasis on cost containment in health care. Under the present system of prospective payment and Diagnosis Related Groups (DRG's), hospitals are containing costs by discharging patients earlier and with higher levels of acuity to nursing homes and the community. As a result, nursing homes are serving more frequently as an intermediate step between hospitalization and community based care. Patient needs are often similar in all of these settings so nurses need to integrate care between acute and long-term care facilities and employ a means of communication that will augment patient progress.

Although most older adults enter long-term care from an acute care facility, many elders also move between the nursing home, hospital and nursing home.¹ Therefore, the need for a method of continual communication among nurses at different level exists. We already use discharge plans and transfer orders, but are these sufficient to meet patient needs? Is there a continuous, patient-oriented, dynamic plan exchanged between care-givers?

Currently, each level of care assesses elders upon transfer. This is appropriate because a patient's status is dynamic. Periodic reassessment and evaluation of the status of the patient is required as is refocusing of the problem and the plan of care. However, each institution emphasizes problem identification

according to its own focus of care. E.g., in acute care, nurses focus on current problems warranting admission to the hospital-- problems with oxygenation, circulation, and acute pain. Discharge planners assess areas of independence and need for assistance with activities of daily living, continence, ability to administer medications, and evaluate for the most cost effective discharge arrangements. Nurses in long-term care assess patients for ability with feeding, mobility, and toileting.

I realize this is only a fragment of the assessment and planning which is done by each facility. The point is that each institution functions as a separate unit of care, reassessing the same patient and starting at the beginning with a new problem list. Where is the continuity in dealing with the priority problems identified from the previous level of care? Despite the consistency of some problems for the patient, where is the statement for eventual rehabilitation, the record of progress of patient outcomes and movement toward optimal functioning over the long term? This is the bridge we must cross.

I believe nursing diagnosis is the vehicle we can use to bridge care gaps and communicate nursing care along the health care continuum. Gordon says, nursing diagnosis is reserved for client problems which nurses "by virtue of their education and experience are capable and licensed to treat independently."² These nursing diagnoses are the common language all nurses can speak at various levels of care to create continuity in problem identification and promote problem solving within the nursing process.

Patient problems persist till resolved. For example, alteration in urinary pattern/incontinence may be assessed, but the priority in dealing with it in various settings differs. Because a patient transfers to another level of care, progress toward favorable outcomes should not necessarily be terminated. If we use the same systematic process of nursing diagnoses and nursing process as a means of communication among various clinical settings, plans for patient progress can continue. Discharge summaries should include a summary of patient progress toward outcomes for each nursing diagnosis. Nursing interventions can then be adapted according to patient capabilities at each level.

Common patient problems that nurses are licensed to treat often exist for elderly people in all clinical settings. E.g., alterations in skin integrity, nutrition, and immobility. In addition, there are problems that are predictors for institutionalization of older adults. These include difficulties with ADL,^{3,4} lack of social support^{5,6} and change in mental status.^{7,8,9} If we pursue clear communications among all care levels with during diagnosis, especially beginning with these three predictors of institutionalization, we may augment problem identification and patient progress and affect the need for or duration of long-term care. In addition, nursing diagnosis facilitates integration of the plan of care with other health care services and allows nurses to remain accountable for nursing activities.

Besides limiting repetition of problem identification, I see these advantages in using nursing diagnosis among all levels

of care:

1. nurses would be providing definitive care toward the same long-term goal, no matter where the patient relocates or is situated.
2. patient improvement or change in condition would be documented along the entire continuum of health care through the same systematic process. This would also augment quality assurance in care.
3. a possible decrease in need for and/or duration of institutionalization.

Suggestions for initiation of this system as a care bridge between acute and long-term care include:

1. Set up a task force to present education programs on nursing diagnosis for professional nurses from all levels of care.
2. Emphasize the use of the NANDA Taxonomy for a common terminology.
3. Develop a mutual respect for the dysfunctions in human responses that are commonly seen in elderly people, especially those that are predictors of institutionalization. Use the latter diagnoses as a beginning point.
4. Periodically evaluate implementation and problems that occur at each level of care.
5. Perform quality assurance analysis to chart patient progress in achieving outcomes and long-term goals during movement along the health care continuum.

Theoretically, this is an ideal situation. What are some of the inherent problems in instituting nursing diagnosis as a bridge between levels of care?

1. Belief in nursing diagnosis. By virtue of your presence here, I believe you have some vested interest in the process. But there are many non-believers who need to be converted.
2. The lack of nursing diagnosis skills for all professional nurses in acute and long-term care.
3. Time allotment for education about nursing diagnosis within the limits of staffing patterns.
4. Adequate numbers of professional nurses in long-term care to assess clients and formulate nursing diagnoses.
5. Cooperation of professional nurses and administration between acute and long-term care.

To demonstrate the efficacy of using nursing diagnosis between acute and long-term care, I've included a sample nursing diagnosis and plans for all levels of care. The problem is alteration in urinary elimination/incontinence. Hopefully, this will provide a stimulus for further development.

ALTERATION IN ELIMINATION: INCONTINENCE

ACUTE CARE

OUTCOMES:

Patient voids when placed on bedpan.
Patient remains continent.
Patient verbalizes bladder training plan.

INTERVENTIONS:

Place call light within reach of patient. Inform staff to answer light immediately.
Instruct patient to call on urge to void.

Deliver 100cc total intake every hour. Inform patient of reason for intake.

Decrease intake to 50cc every hour at night.

Place patient on bedpan every hour during day and every 2 hours at night. When successful, increase time to

NURSING HOME

OUTCOMES:

Patient voids when placed on bedside commode or bedpan.
Patient remains continent.
Patient verbalizes bladder training plan.
Patient demonstrates Kegel exercises.

INTERVENTIONS:

Place call light within reach of patient. Inform staff to answer light immediately.
Instruct patient to call on urge to void.

Instruct patient to drink one full glass of fluid every two hours. Place a time schedule on bedside stand and ensure that clock can be seen.

Offer the bedpan every four hours at night. Decrease nighttime intake according to desire.

COMMUNITY CARE

OUTCOMES:

Client remain continent.
Client seeks assistance to go to the bathroom.
Client demonstrates knowledge of bladder training program.
Client performs Kegel exercises.

INTERVENTIONS:

Instruct client to drink a glass of fluid every two hours during the day.
Instruct caretaker to keep a pitcher of fluid nearby.

Instruct client to call for assistance to bathroom immediately at the urge to void.

Instruct client and caretaker to maintain a voiding record. If incontinence occurs, adjust voiding schedule.

ACUTE CARE

every 2 hours during day and
and every 4 hours at night.
Teach patient about the timed
schedule for voiding.

Assess the patient frequently
for wetness. Teach patient
to call if linens are wet.

Keep perineum clean and dry.
Ensure that linen and absorb-
ant pads are dry and plastic
does not come in contact with
skin.

Maintain a voiding record of
time and amount voided and
time of incontinence.

Adjust bedpan schedule
according to voiding
record.

NURSING HOME

Assist the patient onto the
bedside commode or bedpan
about 30 minutes later.
Instruct the patient to call
when it is time to void.
Teach the patient about the
bladder training program.

When patient remain continent,
increase voiding schedule to
every 3, then 4 hours and as
needed.

Instruct patient on Kegel
exercises (have patient
verbalize and demonstrate
steps).

Maintain a voiding record of
time and amount voided and
time of incontinence. Adjust
voiding schedule according to
voiding record.

Maintain skin care program.

COMMUNITY CARE

Instruct client and care-
taker to schedule a time
to void during the night.

Teach caretaker appropriate
body mechanics to assist
client.

Assess home for easy access
to bathroom. Instruct
caretaker on importance of
clear pathway.
Obtain adequate handgrips in
bathroom to provide support.

Teach client to continue
Kegel exercises. Instruct
caretaker to reinforce
this practice.

Teach client the importance
of remaining dry and to
report wet linen promptly.
Instruct the caretaker on
skin care techniques.

Assess for adequate hand-
washing facility.
Instruct client and
caretaker on importance
of good handwashing.

. . . Running Head: Care Bridges

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